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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DYNAMIC HOME HEALTH CARE, LLC	2865 S JONES LAS VEGAS, NV 89146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS Surveyor: 25418 This Statement of Deficiencies was generated as a result of the Medicare re-certification survey conducted at your agency from 12/1/09 through 12/11/09, in accordance with 42 CFR Part 484 - Home Health Services. The active census on the first day of the survey was 161. Twenty-four clinical records were reviewed, including four closed records. Ten home visits were conducted. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	G 000		
G 116	484.10(f) HOME HEALTH HOTLINE The patient has the right to be advised of the availability of the toll-free HHA hotline in the State. When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the State, the hours of its operation, and that the purpose of the hotline is to receive complaints or questions about local HHAs. The patient also has the right to use this hotline to lodge complaints concerning the implementation of the advanced directives requirements.	G 116		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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G 116	Continued From page 1 This STANDARD is not met as evidenced by: Surveyor: 25418 Based on interview, the agency failed to ensure staff fully explained the availability of the 24 hour home health hotline for 1 of 10 patients visited (Patient #1). Findings include: Patient #1 Patient #1 was admitted on 8/1/09 with diagnoses including non-healing surgical wound, abnormality of gait, essential hypertension and chronic pain. On 12/3/09 in the afternoon during a home visit, Patient #1 indicated he did not receive any information regarding the availability of a toll free home health hotline and when to use it.	G 116		
G 121	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on observation and interview, the agency failed to ensure the nurse followed accepted professionally accepted standards and principles while caring for 2 of 24 patients (Patients #6, #8). Findings include:	G 121		

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G 121	Continued From page 2 Patient #6 Patient #6 was admitted on 9/30/08 with diagnoses including venous peripheral insufficiency, malignant essential hypertension and morbid obesity. Patient #6 had three separate and distinct wounds on the lateral and posterior aspects of the left lower leg. On 12/11/09 during a home visit in the morning, the nurse performed wound care on the three wounds on Patient #5's left lower leg. While cleaning all three of Patient #6's wounds, the nurse wore the same pair of gloves. On 12/11/09 in the afternoon, the Nursing Supervisor (NS) indicated three separate and distinct wounds should be treated as such. The NS indicated she would expect the nurse to change gloves and perform hand hygiene after the care of the first wound and before the care of the second wound. The NS indicated she would expect to see the same glove change/hand hygiene procedure performed between provision of care to the second and third wounds. Patient #8 Patient #8 was admitted on 10/28/08 with diagnoses including insulin dependent diabetes mellitus, diabetic ulcer of the lower leg and chronic airway obstruction. On 12/4/09 in the morning during a home visit, the skilled nurse (SN) performed wound care to Patient #8's lower leg wound.	G 121		

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G 121	Continued From page 3 During the course of Patient #8's wound care, the SN removed both gloves eight times and failed to perform hand hygiene prior to donning a new pair of gloves. On two occasions, the SN changed only one glove without performing hand hygiene prior to donning the new glove(s). The Centers for Disease Control and Prevention's Morbidity and Mortality Report MMWR Recommendations & Reports, published October 25, 2002 recommends, " ...J. Decontaminate hands after removing gloves ... "	G 121		
G 143	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review, the agency failed to ensure employees maintained liaison and coordinated in a way to effectively support the objectives outlined in the plan of care for 9 of 24 patients (Patients #1, #2, #7, #11, #12, #14, #15, #18, #20). Findings include: Patient #1 Patient #1 was admitted on 8/1/09 with diagnoses including non-healing surgical wound, abnormality of gait, essential hypertension and chronic pain.	G 143		

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G 143	Continued From page 4 Patient #1 was seen by skilled nursing (SN) and physical therapy (PT). Patient #1's clinical record lacked documented evidence the two disciplines communicated with each other regarding the patient's problems, needs, etc. during the three certification periods reviewed. Patient #2 Patient #2 was admitted on 11/14/09 with diagnoses including pressure ulcer, non-insulin dependent diabetes, malignant essential hypertension and debility. Patient #2 was seen by skilled nursing (SN) and physical therapy (PT). Patient #2's clinical record included a skilled nurse visit note dated 11/15/09 with a notation the patient would be staying at her granddaughter's house for the week. Patient #2's clinical record lacked documented evidence indicating the PT was notified of the temporary change of address. Patient #3 Patient #3 was admitted on 8/24/09 with diagnoses including decubitus ulcer, malignant neoplasm of the lung and low back pain. Patient #3 was seen by skilled nursing (SN) and physical therapy (PT). Patient #3's clinical record lacked documented	G 143		

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G 143	Continued From page 5 evidence SN and PT communicated with each other regarding the patient's needs, issues and status. Patient #7 Patient #7 was admitted on 11/20/09 with diagnoses including debility, essential hypertension, non-insulin dependent diabetes mellitus, bronchitis and chronic airway obstruction. Patient #7 was seen by skilled nursing (SN) and physical therapy (PT). Patient #7's clinical record lacked documented evidence indicating SN and PT communicated with each other regarding the patient's issues, needs, progress, etc. Patient #11 Patient #11 was admitted on 9/17/09 with diagnoses including pressure ulcer, non insulin dependent diabetes mellitus, debility, essential hypertension and urinary retention. During the certification period of 11/20/09 - 1/18/09, Patient #11 had orders to be seen by skilled nursing (SN) and physical therapy (PT). A SN note dated 11/25/09 from 11:00 AM to 11:45 AM revealed the SN sent Patient #11 to the emergency room via ambulance. A 11/25/09 missed visit form prepared by PT revealed "Patient was not home ... didn't call to cancel; wasn't home."	G 143		

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G 143	Continued From page 6 Patient #11's clinical record lacked evidence the two disciplines communicated with each other regarding the patient's status. Patient #12 Patient #12 was admitted on 11/15/09 with diagnoses including essential hypertension, abnormality of gait and acute pain. Patient #12 was seen by skilled nursing (SN) and physical therapy (PT). Patient #12's clinical record lacked documented evidence the two disciplines communicated with each other regarding the patient's needs, issues and progress. Patient #14 Patient #14 was originally admitted on 1/16/09 with diagnoses including insulin dependent diabetes mellitus and four wounds on the lower extremities. Over the course of 12 months, the patient was readmitted to the acute care setting three times: on 1/22/09 for deterioration/infection of wound(s) and subsequent amputation of the 4th and 5th left toes; on 8/26/09 for infection of wound; on 10/7/09 for respiratory issues (and bilateral below the knee amputations on 10/13/09). Patient #14's most recent readmission was on 11/6/09. The patient was being seen by skilled nursing, physical therapy and occupational therapy. Patient #14's clinical record lacked documented evidence the three disciplines communicated with	G 143		

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G 143	Continued From page 7 one another regarding the patient's issues, progress and concerns. Patient #18 Patient #18 was admitted on 11/26/09 with diagnoses including muscle weakness, essential hypertension, and asthma. Patient #18 was seen by skilled nursing and physical therapy. The clinical record lacked documented evidence the two disciplines communicated with each other regarding the patient's needs, issues and progress. Patient #20 Patient #20 was admitted on 7/10/09 with diagnoses including insulin dependent diabetes mellitus, pressure ulcers, debility and malignant neoplasm of the skin. Patient #20 was seen by skilled nursing (SN) and occupational therapy (OT). The patient's clinical record lacked documented evidence the two disciplines communicated with each other regarding the patient's needs, issues and progress/lack of progress. Patient #20's 30-day summary was signed by SN but not OT.	G 143		
G 144	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.	G 144		

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G 144	Continued From page 8	G 144		

This STANDARD is not met as evidenced by:
Surveyor: 25418
Based on record review, interview and document review, the agency failed to ensure case conferences occurred on a regular basis for 3 of 24 patients (Patients #11, #12, #14).

Findings include:

Patient #11

Patient #11 was originally admitted on 9/17/09 with diagnoses including pressure ulcers, non insulin dependent diabetes mellitus, debility, essential hypertension and urinary retention.

Patient #11 was seen by skilled nursing, certified nursing assistant and physical therapy.

A 10/14/09 skilled nursing visit note revealed Patient #11 was sent to the emergency room on that date.

Patient #11 was readmitted on 11/20/09 with diagnoses including debility, pressure ulcers, non insulin dependent diabetes mellitus, debility and essential hypertension.

Patient #11's clinical record lacked documented evidence of case conferences being held by the disciplines involved in the case (skilled nurse, certified nursing assistant, physical therapist).

Patient #12

Patient #12 was admitted on 11/15/09 with diagnoses including essential hypertension,

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G 144	Continued From page 9 abnormality of gait and acute pain. Patient #12 was seen by skilled nursing, physical therapy and occupational therapy. Patient #12's clinical record lacked documented evidence the three disciplines held a case conference to discuss the patient's problems, issues, progress, etc. Patient #14 Patient #14 was originally admitted on 1/16/09 with diagnoses including insulin dependent diabetes mellitus and four wounds on the lower extremities. Over the course of 12 months, Patient #14 was readmitted to the acute care setting three times: on 1/22/09 for deterioration/infection of wounds (and subsequent amputation of the 4th and 5th left toes); on 8/26/09 for infection of wound; on 10/7/09 for respiratory issues (and bilateral below the knee amputations on 10/13/09). Patient #14's most recent readmission to the agency was on 11/6/09. The patient was being seen by skilled nursing, physical therapy and occupational therapy. Patient #14's clinical record lacked documented evidence the three disciplines held a case conference to discuss the patient's problems, issues, progress, etc. On 12/11/09 in the afternoon, the Administrator indicated "Case conferences are held every month ... a list is prepared with any 'interesting' cases, patients being recertified, having wounds	G 144		

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G 144	Continued From page 10 ... random selection unless there is an ongoing problem."	G 144		
G 145	484.14(g) COORDINATION OF PATIENT SERVICES A written summary report for each patient is sent to the attending physician at least every 60 days. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review, the agency failed to ensure a complete 60 day summary was prepared and sent to the physician for 3 of 24 patients (Patients #1, #6, #9). Findings include: Patient #1 Patient #1 was admitted on 8/1/09 with diagnoses including non-healing surgical wound, abnormality of gait, essential hypertension, hypercholesteremia and chronic pain. The 60 day summary written for Patient #1's first certification period of 8/1/09 - 9/29/09 indicated two medications (Prinivil and Simvastatin) were discontinued. There was no explanation why the patient was taken off medications used to treat hypertension and hypercholesteremia. The same 60 day summary for Patient #1 indicated the Keflex dosage was changed and revealed the amount the patient was taking at that time. There was no indication what dosage the patient had been on and what necessitated the change in dosage of the antibiotic.	G 145		

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G 145	Continued From page 11 Patient #1's current wound measurements were included in the 60 day summary. There were no measurements of the wound from the beginning of the 60 day period with which to compare the current measurements. There was no indication the wound was debrided (and when) and the measurements before and after the procedure. There was no documentation regarding the type and amount of drainage at the beginning (and end) of certification period. During the first certification period, Patient #1's wound was treated with a wound VAC (vacuum assisted closure). There was no documentation indicating how the wound responded to the VAC and the reason for its discontinuation. Patient #6 Patient #6 was admitted on 9/30/08 with diagnoses including venous peripheral insufficiency, malignant essential hypertension and morbid obesity. As of 12/11/09, Patient #6 had three separate and distinct wounds on the medial and posterior aspects of the left lower leg. The skilled nurse indicated "as soon as one heals, another one appears." The 60 day summary for the certification period of 9/25/09 - 11/23/09 revealed Patient #6 had two open areas on the lower left leg. The description of both wounds did not include the depth of either one. There were no measurements from the start of the certification period with which to compare the current measurements. There was no documentation regarding the type and amount of	G 145		

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G 145	Continued From page 12 drainage at the beginning (and end) of certification period. Patient #6's 60 day summary for the certification period of 9/25/09 - 11/23/09 did not include progress toward goals indicated in the previous certification period's Plan of Care goals section. Patient #9 Patient #9 was admitted on 2/25/09 with diagnoses including pressure ulcer of the buttock, essential hypertension, obesity and low back pain. Patient #9's 60 day summary for the certification period 8/24/09 - 10/22/09 did not include: a) mention of a trip to Urgent Care and new medications for a urinary tract infection; b) wound measurements from the beginning of the certification period with which to compare the current measurements; c) the addition of Emla cream to the wound as needed for pain; and d) the addition of Interdry Ag (silver) skin protectant to the wound.	G 145		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review and document review,	G 158		

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the agency failed to ensure care followed an established written plan periodically reviewed by a physician for 12 of 24 patients (Patients #1, #2, #3, #10, #11, #14, #17, #19, #20, #22, #23, #24).

Findings include:

Patient #1

Patient #1 was admitted on 8/1/09 with diagnoses including non-healing surgical wound, abnormality of gait, essential hypertension and chronic pain.

Patient #1's Plan of Care (POC) for the certification period of 8/1/09 - 9/29/09 called for skilled nursing (SN) to see the patient one time a week for one week and three times a week for seven weeks.

As revealed by the missed visit forms dated 8/17, 8/19 and 8/21/09, SN did not see Patient #1 during the fourth week.

Missed visit forms dated 8/28, 9/3, 9/8, 9/9, 9/10 and 9/28/09 revealed SN did not see Patient #1 for the ordered number of visits during weeks 5, 6 and 7 of the certification period 8/1/09 - 9/29/09.

Patient #1's clinical record lacked physician's orders decreasing the frequency of SN visits during the affected weeks.

Patient #1's POC included orders for "...wound vac (vacuum assisted closure) at 175 (mm/hg)." The order did not specify if the setting was to be continuous or intermittent.

SN notes dated 8/3, 8/6, 8/8, 8/11 and 8/13/09 indicated Patient #1's wound vac was set at 125

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mm/hg. The notes did not reveal if the setting was continuous or intermittent.

Patient #2

Patient #2 was admitted on 11/14/09 with diagnoses including pressure ulcer, non-insulin dependent diabetes, malignant essential hypertension and debility.

Patient #2's Plan of Care (POC) for the certification period of 11/14/09 - 1/12/10 called for skilled nursing (SN) to see the patient two times a week for one week, seven times a week for one week and then two times a week for one week.

According to documentation in Patient #2's clinical record, SN saw the patient two times the first week and four times the second week. The clinical record lacked a physician's order decreasing the SN visits during the second week of service.

Patient #3

Patient #3 was admitted on 8/24/09 with diagnoses including decubitus ulcer malignant neoplasm of the lung and low back pain.

Patient #3's Plan of Care (POC) for the certification period of 8/24/09 - 10/22/09 called for skilled nursing (SN) to see the patient three times a week for three weeks.

On 9/6/09, the SN obtained a physician's order for a frequency of three times a week for seven weeks with three prn (as needed) visits for wound problems. As of 9/6/09, only six weeks remained in Patient #3's certification period.

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G 158	Continued From page 15 Patient #3's clinical record included a physical therapy (PT) evaluation dated 9/26/09. There was no order for PT evaluation in the patient's clinical record. PT wrote for a frequency of one time a week for one week and two times a week for four weeks. As of 12/3/09, the order was not signed by the physician. Patient #3's clinical record lacked documented evidence of 14 SN visits from 8/31/09 through 10/22/09. The clinical record included three missed visit forms. The rest of the 11 ordered visits were unaccounted for. Patient #3's POC for the certification period of 10/23/09 - 12/21/09 included orders for SN to see the patient two times a week for nine weeks with 3 prn wound complications. The certification period of 10/23/09 - 12/21/09 began on a Friday. Patient #3 was seen once that week, on Sunday. On 11/1/09, Patient #3 was transported to an acute care facility secondary to shortness of breath. The resumption of care (ROC) order for Patient #3 indicated the patient was to be seen once a day for five days in a row. The clinical record lacked documented evidence of a SNVN for 11/21/09. There was no missed visit form dated 11/21/09. There was no physician's order decreasing the number of SN visits for that week. Patient #10	G 158		

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G 158	Continued From page 16 Patient #10 was admitted on 10/23/09 with diagnoses including debility, essential hypertension and dehydration. Patient #10 was seen by skilled nursing (SN) and physical therapy (PT). Patient #10's Plan of Care (POC) for the certification period of 10/23/09 - 12/21/09, included orders for the patient to be seen by skilled nursing (SN) once a week for one week, three times a week for one week and then once a week for two weeks. According to SN notes in Patient #10's clinical record, SN saw the patient once a week for five weeks. There was one missed visit form (dated 10/26/09) in the clinical record. The agency's week ended on Sunday. OT saw Patient #10 on Friday, 11/20/09 and wrote an order for the patient to be seen three times a week for four weeks. The order did not specify, "Beginning the week of 11/23/09..." Patient #11 Patient #11 was admitted on 9/17/09 with diagnoses including pressure ulcer, non insulin dependent diabetes mellitus, debility, essential hypertension and urinary retention. Patient #11's clinical record contained a Supplementary Physician's Order dated by the nurse on 9/23/09 revealing new wound card protocol. As of 12/11/09, Patient #11's clinical record	G 158		

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G 158	Continued From page 17 lacked a signed Supplementary Physician's Order dated 9/23/09 changing the wound care protocol. Patient #14 Patient #14 was originally admitted on 1/16/09 with diagnoses including insulin dependent diabetes mellitus and four wounds on the lower extremities. Over the course of 12 months, Patient #14 was readmitted to the acute care setting three times: on 1/22/09 for deterioration/infection of wound(s) and subsequent amputation of the 4th and 5th left toes; on 8/26/09 for infection of wound; on 10/7/09 for respiratory issues (and bilateral below the knee amputations on 10/13/09). Patient #14's most recent resumption of care was on 11/6/09 (during the certification period 9/13/09 - 11/11/09). The patient was being seen by skilled nursing, physical therapy and occupational therapy. Patient #14's clinical record included a 11/6/09 physician's order to resume skilled nursing (SN) services at a frequency of one time a week for two weeks. There was less than one full week left in the certification period. Patient #14's clinical record included a 11/6/09 physician's order to resume physical therapy (PT) services at a frequency of once a week for one week and two times a week for three weeks. The clinical record lacked documented evidence of two PT visits during the week of 11/9/09. Patient #14's clinical record included a 11/6/09 physician's order to resume occupational therapy	G 158		

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G 158	Continued From page 18 (OT) services at a frequency of once a week for one week, two times a week for three weeks and once a week for one week. Patient #14's clinical record lacked documented evidence of OT visits during the weeks of 11/6/09 and 11/16/09. Patient #17 Patient #17 was admitted on 12/1/09 with diagnoses including coronary artery disease and multiple pressure ulcers. Patient #17's Plan of Care included orders for skilled nursing to see the patient every day for 14 days. The clinical record lacked a nursing note for 12/2/09. Patient #17's clinical record did not include a missed visit form indicating 1) why the patient was not seen; and 2) the physician was notified of the same. There was no physician's order decreasing the SN visits. Patient #19 Patient #19 was admitted on 11/13/09 with diagnoses including an open surgical wound of the abdominal wall, open surgical wound of the right buttock and non insulin dependent diabetes mellitus. Patient #19's Plan of Care included orders for skilled nursing (SN) to "... instruct regarding disease process, control of risk factors, possible complications and home management of open wounds ... NIDDM (non insulin dependent diabetes mellitus with s/sx (signs and symptoms)	G 158		

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to report to MD. Actions, uses, frequency, dose, side effects, interactions of all new/changed medications... nutritional/hydration needs, use of glucometer, diabetic management, skin/foot care, ... s/sx infection, infection control ..."

According to 23 skilled nursing visit notes (SNVN) reviewed, the nurse instructed Patient #19 regarding universal precautions eight times, wound care nine times, general hygiene three times, diabetic diet 19 times (one included diabetic mat (materials)), general wound care two times, fall precautions one time, open wound eight times, hydration nine times, medications (all) one time, general precautions two times, diabetic care two times and skin care of the diabetic one time.

The documentation on Patient #19's SNVNs was very general. There was no documentation indicating exactly what the patient was taught about the wounds, medications (dose, frequency purpose/action, side effects), specific foods and amounts for a diabetic diet and wound healing.

The SNVNs lacked documented evidence Patient #19 and or the caregiver verbalized understanding regarding the information the nurse gave them.

The SNVNs lacked documented evidence Patient #19 and or the caregiver gave a return demonstration of the wound care.

A SNVN dated 11/22/09 revealed Patient #19 fell "during the last 24 hours."

The clinical record lacked documented evidence the nurse notified Patient #19's physician of the

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fall.

A SNVN dated 11/23/09 revealed there was "deep tunneling" of Patient #19's buttock wound.

The clinical record lacked documented evidence the nurse notified Patient #19's physician of changes in the wound condition.

Documentation on several of Patient #19's nursing notes revealed the patient was non-compliant with medications.

There was no evidence the physician was notified of Patient #19's non-compliance with medications.

Patient #20

Patient #20 was admitted on 7/10/09 with diagnoses including insulin dependent diabetes mellitus, pressure ulcers, malignant neoplasm of the skin and debility.

Patient #20's Plan of Care (POC) included orders to be seen by skilled nursing (SN) every day for 21 days.

Patient #20's clinical record lacked documented evidence SN saw the patient on 7/20/09 and 7/24/09. There were no missed visit forms indicating the physician was notified of the missed visits. The clinical record lacked a physician's order decreasing SN visits.

Patient #20's POC included orders for occupational therapy (OT) to evaluate the patient.

The OT's 7/17/09 evaluation revealed Patient #20

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G 158	Continued From page 21 was evaluated six days after admission. Patient #20's OT orders were for a frequency of one time a week for six weeks. Patient #20's clinical record lacked documented evidence of an OT visit during the week of 7/20/09. There was no documented evidence the physician was notified of the missed visit. The clinical record lacked a physician's order decreasing the frequency of OT visits. Patient #22 Patient #22 was admitted on 5/21/09 with diagnoses including non insulin dependent diabetes mellitus, osteoarthrosis, chronic pain and debility. Patient #22's Plan of Care included orders for Physical Therapy (PT) to see the patient three times a week for two weeks and then, two times a week for three weeks. The PT evaluation was dated 5/26/09, the second day in the second week of Patient #22's certification period. There was no documentation indicating why PT evaluated the patient six days after admission. Patient #22's physical therapy (PT) Resumption of Care done on 6/1/09 included orders for PT twice a week for four weeks. Documentation in Patient #22's clinical record indicated PT saw the patient two times a week for three weeks and then did not see the patient the third week.	G 158		

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Patient #22's clinical record lacked missed visit forms indicating why the patient was not seen, evidence the physician was notified of the missed visits, and an order decreasing the frequence of PT visits.

Patient #23

Patient #23 was admitted on 5/22/09 with diagnoses including acute pain, abnormality of gait, long term use of anticoagulants and debility.

The evaluation revealed Patient #23 was seen by PT for the first time on 5/27/09. There was no documented evidence indicating why PT did not see the patient within 48 hours of the referral.

Patient #23's Plan of Care (POC) included orders for physical therapy (PT) to see the patient three times a week for three weeks. There was no indication the visits were to start on 5/27/09.

Patient #23's clinical record revealed PT saw the patient three times a week for the first week and then, one time a week for two weeks.

Patient #24

Patient #24 was admitted on 5/15/09 with diagnoses including cerebral palsy, dysphagia, pneumonia and convulsions.

Patient #24's Plan of Care included orders for certified nursing assistant (CNA) once a week for one week and then, two times a week for eight weeks.

According to documentation in the clinical record, the CNA did not see Patient #24 the first week

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G 158	Continued From page 23 and saw the patient one time the second week. On 12/11/09 in the afternoon, the Nursing Supervisor indicated the policy for additional disciplines to evaluate was 48 hours from the time the referral was received. According to the agency's Plan of Care Policy, effective 05/08, "... Procedure...7. f. If a missed visit does not change the frequency, a communication note must be written explaining the circumstances of the missed visit and the physician must be notified. If a missed visit changes the frequency, the physician must be notified and an order must be obtained to change the frequency..."	G 158		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review and observation, the agency failed to ensure medical equipment and supplies were included in the plan of care for 8 of 24 patients (Patients #3, #5, #6, #7, #8, #9, #12, #13).	G 159		

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Findings include:

Patient #3

Patient #3 was admitted on 8/24/09 with diagnoses including decubitus ulcer malignant neoplasm of the lung and low back pain.

Patient #3's Plan of Care (POC) listed "non-sterile gloves, 4x4's (gauze), saline, Duoderm, Tegaderm and walker."

On 12/3/09 in the afternoon during a home visit, Patient #2 had a bedside commode, a shower chair, a manual wheelchair, an oxygen concentrator, oxygen tubing and portable oxygen tanks.

Patient #5

Patient #5 was admitted on 11/29/09 with diagnoses including pulmonary embolism, abnormality of gait, aftercare surgery of musculoskeletal system, degenerative joint disease.

Patient #5's Plan of Care (POC) listed "non-sterile gloves."

On 12/3/09 in the morning during a home visit, Patient #5 had a bedside commode, a walker and a small volume nebulizer.

Patient #6

Patient #6 was admitted on 9/30/08 with diagnoses including venous peripheral insufficiency, malignant essential hypertension and morbid obesity.

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G 159	Continued From page 25 The Plan of Care (POC) for the certification period of 11/24/09 - 1/22/10 listed "non-sterile gloves." On 12/11/09 in the morning during a home visit, Patient #6 indicated she had a grab bar in the walk-in shower (this was not visualized as several dogs were locked in the patient's master bed/bathroom), a hand held shower unit, a walker and a wheel chair. There were multiple wound care supplies (gauze, ace wraps, specialty dressings, tape, normal saline) in a covered plastic storage bin. Patient #7 Patient #7 was admitted on 11/20/09 with diagnoses including debility, essential hypertension, non-insulin dependent diabetes mellitus, bronchitis and chronic airway obstruction. Patient #7's Plan of Care listed "non-sterile gloves." On 12/4/09 in the morning during a home visit, Patient #7 had a walker and a small volume nebulizer. Patient #8 Patient #8 was admitted on 10/28/08 with diagnoses including insulin dependent diabetes mellitus, diabetic ulcer of the lower leg and chronic airway obstruction. Patient #8's Plan of Care listed "non-sterile gloves."	G 159		

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G 159	Continued From page 26 On 12/4/09 in the late morning during a home visit, Patient #8 had a manual wheelchair and a Hoyer lift. Patient #9 Patient #9 was admitted on 2/25/09 with diagnoses including pressure ulcer of the buttock, essential hypertension, obesity and low back pain. Patient #9's Plan of Care listed "non-sterile gloves." On 12/4/09 in the afternoon during a home visit, Patient #9 had a hospital bed, a trapeze, a motorized wheelchair, a transfer board and wound care supplies. Patient #12 Patient #12 was admitted on 11/15/09 with diagnoses including essential hypertension, abnormality of gait and acute pain. Patient #12's Plan of Care listed "non-sterile gloves." On 12/8/09 in the morning during a home visit, Patient #12 had a walker, manual wheelchair, bedside commode, hand held shower and transfer bench. Patient #13 Patient #13 was admitted on 12/5/09 with diagnoses including osteomyelitis, insulin dependent diabetes mellitus, essential	G 159		

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G 159	Continued From page 27 hypertension, atrial fibrillation and coronary atherosclerosis. Patient #13's Plan of Care listed non-sterile gloves and wound care supplies. On 12/8/09 in the afternoon during a home visit, Patient #13 had a manual wheelchair, a reacher and five small portable oxygen tanks.	G 159		
G 161	484.18(a) PLAN OF CARE Orders for therapy services include the specific procedures and modalities to be used and the amount, frequency, and duration. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review, the agency failed to ensure orders included all necessary documentation in the plan of care for 1 of 24 patients (Patient #20). Findings include: Patient #20 Patient #20 was admitted on 7/10/09 with diagnoses including insulin dependent diabetes mellitus, pressure ulcers, debility and malignant neoplasm of the skin. The OT evaluated Patient #20 on 7/17/09. The OT orders lacked documentation indicating the frequency was effective as of 7/17/09.	G 161		
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by	G 165		

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G 165	Continued From page 28 agency staff only as ordered by the physician. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review, the agency failed to ensure drugs and treatments were administered only as ordered by the physician for 8 of 24 patients (Patients #1, #2, #3, #9, #10, #18, #22, #23). Findings include: Patient #1 Patient #1 was admitted on 8/1/09 with diagnoses including non-healing surgical wound, abnormality of gait, essential hypertension and chronic pain. An 8/8/09 skilled nursing (SN) note revealed the nurse placed Xeroform gauze on Patient #1's exposed tendon. There were no orders in the clinical record for Xeroform gauze. SN notes dated 8/11, 8/13 and 8/15/09 revealed the nurse placed Adaptic dressing to Patient #1's exposed tendon. There were no orders in the clinical record for Adaptic dressing. SN notes dated 8/24 and 8/26/09 revealed the nurse placed Mepitel to Patient #1's exposed tendon. There were no orders in the clinical record for Mepitel. Patient #2 Patient #2 was admitted on 11/14/09 with diagnoses including pressure ulcer, non-insulin	G 165		

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dependent diabetes, malignant essential hypertension and debility.

Patient #2's Plan of Care (POC) included orders for wound care reading, "...cleanse with NS (normal saline), apply hydrogel and DSD (dry sterile dressing)."

According to a skilled nurse visit note (SNVN) dated 11/19/09, the nurse called the physician and received an order to change Patient #2's wound care to "Duoderm patch 2xweek (two times a week)."

Documentation on the 11/19/09 SNVN revealed the nurse used "Skin prep to peri-wound area" prior to applying the Duoderm patch to Patient #2's wound.

Patient #2's clinical record lacked documented evidence of a physician's order for skin prep.

Patient #3

Patient #3 was admitted on 8/24/09 with diagnoses including decubitus ulcer, malignant neoplasm of the lung and low back pain.

Patient #3's clinical record contained a skilled nursing visit note (SNVN) dated 10/26/09. According to the notation on the form, the visit was unscheduled and made because the patient had an increase in cough and phlegm.

Patient #3's clinical record lacked a physician's order for an unscheduled visit for the purpose of an increase in cough and phlegm.

Patient #9

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G 165	Continued From page 30 Patient #9 was admitted on 2/25/09 with diagnoses including pressure ulcer of the buttock, essential hypertension, obesity and low back pain. Documentation on the 11/16/09 SNVN indicated a physician's order for Docusate 200 milligrams po (by mouth) every day was obtained. Patient #9's clinical record lacked a physician's order for Docusate. Patient #10 Patient #10 was admitted on 10/23/09 with diagnoses including debility, essential hypertension and dehydration. Patient #10's Plan of Care for the certification period included orders for the skilled nurse (SN) to see the patient one time a week for one week, three times a week for one week and one time a week for two weeks. SN saw Patient #10 one time during the week of 11/16/09. The clinical record lacked documented evidence of a physician's order for a SN visit the week of 11/16/09. Patient #18 Patient #18 was admitted on 11/26/09 with diagnoses including muscle weakness, essential hypertension, and asthma. Patient #18's Plan of Care included orders for PT to see the patient one time a week for one week, two times a week for one week and then, three times a week for three weeks.	G 165		

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G 165	Continued From page 31 Patient #18's clinical record included visit notes indicating PT saw the patient one time a week for one week and then three times a week for one week. Patient #22 Patient #22 was admitted on 5/21/09 with diagnoses including non insulin dependent diabetes mellitus, osteoarthrosis, chronic pain and debility. Patient #22's physical therapy (PT) Resumption of Care done on 6/16/09 included orders for PT two times a week for four weeks. Documentation in Patient #22's clinical record indicated PT saw the patient two times a week for three weeks, did not see the patient for one week; then saw the patient two times a week for one week. Patient #22's clinical record included a physician's order dated 7/8/09 for skilled nursing (SN) visits once a week for six weeks. The patient was seen by SN two times during the week of 7/13/09. Patient #23 Patient #23 was admitted on 5/22/09 with diagnoses including acute pain, abnormality of gait, long term use of anticoagulants and debility. Patient #23 was seen by physical therapy (PT). On 7/14/09, a registered nurse took a verbal order from the physician's office for Patient #23. The order read, "D/C (discontinue) SN (skilled	G 165		

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G 165	Continued From page 32 nursing) services...PT services to continue." The order did not include the amount, frequency and duration of visits PT was to provide. According to documentation in Patient #23's clinical record, PT saw the patient two times a week for one week, one time a week for two weeks, did not see the patient for one week and then, two times a week for one week, beginning the week of 6/15/09.	G 165		
G 166	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review, the agency failed to ensure physicians' orders were signed and dated in a timely manner for 2 of 24 patients (Patient #3, #9). Findings include: Patient #3 Patient #3 was admitted on 8/24/09 with diagnoses including decubitus ulcer, malignant neoplasm of the lung and low back pain. Patient #3's clinical record included three	G 166		

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G 166	Continued From page 33 physician's orders, dated 9/6/09, 10/6/09 and 10/9/09. As of 12/3/09, all three orders lacked a physician's signature and date. On 9/26/09, PT wrote an order for Patient #3 to have treatments one time a week for one week and two times a week for four weeks. As of 12/3/09, the order was not signed or dated by the physician. Patient #9 Patient #9 was admitted on 2/25/09 with diagnoses including pressure ulcer of the buttock, essential hypertension, obesity and low back pain. As of 12/8/09, Patient #9's Plan of Care for the certification period 10/23/09 - 12/21/09 lacked a physician's signature and date.	G 166		
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review, the agency failed to ensure the nurse prepared complete and accurate physician's orders, clinical notes and progress notes for 8 of 24 patients (Patients #1, #2, #3, #6, #13, #14, #16, #22). Findings include:	G 176		

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G 176	Continued From page 34 Patient #1 Patient #1 was admitted on 8/1/09 with diagnoses including non-healing surgical wound, abnormality of gait, essential hypertension and chronic pain. Patient #1's Plan of Care (POC) for the initial certification period included orders for "wound vac (vacuum assisted closure) changes 3w - 1st change. Monday 8/3/09 irrigate with NS (normal saline) - redress with vac dressing to vac @ 175." The order did not include whether the negative pressure created by the vac was to be continuous or intermittent. The skilled nurse (SN) notes did not indicate whether the vac setting was for continuous or intermittent. There was no documentation in Patient #1's clinical record indicating the SN called the physician to verify if the pressure was to be continuous or intermittent. Physician's orders dated 9/4/09 and 9/9/09 indicated the dressing was to be changed. However, the order did not specify who was to do the dressing change - the SN or Patient #1. Patient #2 Patient #2 was admitted on 11/14/09 with diagnoses including pressure ulcer, non-insulin dependent diabetes, malignant essential hypertension and debility. Patient #2's Plan of Care (POC) included orders for "... SN (skilled nursing) to perform: ... Decub (decubitus) care as follows: Right buttock...cleanse with NS (normal saline), apply	G 176		

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G 176	Continued From page 35 hydrogel and DSD (dry sterile dressing)..." Patient #2's wound care orders did not include how the DSD was to be secured and how often the care was to be provided. Patient #2's clinical record included seven skilled nursing visit notes which indicated the patient did not have the necessary equipment to check her blood glucose levels. There was no documentation indicating the nurse notified the physician of the situation. There was no documentation indicating the nurse attempted to assist the patient to obtain the equipment by getting an order for a social worker to intervene. Patient #3 Patient #3 was admitted on 8/24/09 with diagnoses including decubitus ulcer, malignant neoplasm of the lung and low back pain. Patient #3's clinical record included documentation on a 9/6/09 skilled nursing visit note (SNVN) indicating the patient fell during the night of 9/5/09, went to the emergency room, was treated and returned home. Patient #3's clinical record lacked documented evidence the SN notified the physician of the patient's fall on 9/5/09. Patient #6 Patient #6 was admitted on 9/30/08 with diagnoses including venous peripheral insufficiency, malignant essential hypertension and morbid obesity.	G 176		

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G 176	Continued From page 36 Patient #6's clinical record lacked documentation of wound care provided on 11/23/09 in the Recertification Assessment on page 10. Multiple wound assessment tools in Patient #6's clinical record lacked a complete measurement of the wounds. The majority of nursing documentation in the clinical record was illegible. Patient #13 Patient #13 was admitted on 12/5/09 with diagnoses including osteomyelitis, insulin dependent diabetes mellitus, essential hypertension, atrial fibrillation and coronary atherosclerosis. Patient #13 was admitted by skilled nursing (SN) on a Sunday, the last day of the agency's week. SN prepared orders to see the patient seven times a week for two weeks. Patient #14 Patient #14 was originally admitted on 1/16/09 with diagnoses including insulin dependent diabetes mellitus and four wounds on the lower extremities. Over the course of 12 months, Patient #14 was readmitted to the acute care setting three times: on 1/22/09 for deterioration/infection of wound(s) and subsequent amputation of the 4th and 5th left toes; on 8/26/09 for infection of wound; on 10/7/09 for respiratory issues (and bilateral below the knee amputations on 10/13/09). Patient #14's most recent resumption of care was on 11/6/09. The patient was being seen by skilled	G 176		

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G 176	Continued From page 37 nursing, physical therapy and occupational therapy. Patient #14's clinical record contained multiple nursing notes, 60 day summaries, case conferences and medication profiles with numerous blanks, incomplete dates, signatures missing and illegible handwriting. Patient #14's clinical record included a physician's order to resume physical therapy (PT) services at a frequency of one time a week for one week and two times a week for three weeks. The order was dated 11/6/09. The last day of the certification period was 11/11/09, less than one week later. Patient #14's clinical record included a physician's order to resume occupational therapy (OT)services at a frequency of one time a week for one week, two times a week for three weeks and once a week for one week. The order was dated 11/6/09. The last day of the certification period was 11/11/09, less than one week later. Patient #16 Patient #16 was admitted on 11/4/09 with diagnoses including non insulin dependent diabetes mellitus, chronic pain and open wound. The OASIS (Outcome and Assessment Information Set) prepared by the nurse upon admission lacked documentation of the depth of Patient #16's wounds. The orders for wound VAC (vacuum assisted closure) therapy in Patient #16's Plan of Care lacked documentation indicating whether the negative pressure was to be continuous or	G 176		

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G 176	Continued From page 38 intermittent. Subsequent orders and skilled nursing visit notes lacked documentation indicating the negative pressure was (to be) set at continuous or intermittent. Patient #22 Patient #22 was admitted on 5/21/09 with diagnoses including non insulin dependent diabetes mellitus, osteoarthrosis, chronic pain and debility. Patient #22's certification period was from 5/21/09 through 7/19/09. On 7/8/09 (less than two weeks from the end of the certification period), the nurse prepared a physician's order for nursing once a week for six weeks.	G 176		
G 177	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse counsels the patient and family in meeting nursing and related needs. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review, the agency failed to ensure the nurse instructed the patient and/or caregiver for 3 of 24 patients (Patients #1, #2, #3). Findings include: Patient #1 Patient #1 was admitted on 8/1/09 with diagnoses	G 177		

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G 177	Continued From page 39 including non-healing surgical wound, abnormality of gait, essential hypertension and chronic pain. Patient #1's Plan of Care (POC) included orders for skilled nursing (SN) to instruct "...home management of non-healing wound..." The goals of Patient #1's POC for the initial certification period included, "...Pt/pcg (patient/primary caregiver) independent with wound care in w3 weeks." Patient #1's clinical record contained skilled nursing (SN) notes dated 8/3, 8/6, 8/8, 8/11, 8/13, 8/15, 8/24, 8/26 and 9/21/09 which described the wound care provided. None of the SN notes indicated Patient #1 and/or the caregiver was instructed specifically in wound care. There was no indication the patient and/or caregiver verbalized understanding and/or performed a return demonstration of the wound care. The goals of Patient #1's POC for the second certification period indicated, "... Pt/pcg independent with wound care in 6 weeks." Patient #1's clinical record contained SN notes dated 10/19 and 11/5/09. The notes did not indicate Patient #1 and/or the caregiver was instructed specifically in wound care. There was no indication the patient and/or caregiver verbalized understanding and/or performed a return demonstration of the wound care. Patient #2 Patient #2 was admitted on 11/14/09 with	G 177		

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G 177	Continued From page 40	G 177		

diagnoses including pressure ulcer, non-insulin dependent diabetes, malignant essential hypertension and debility.

Patient #2's Medication Profile (MP) revealed the patient was started on Phenergan and Ativan on 11/23/09.

A skilled nurse visit note dated 11/23/09 lacked documented evidence the nurse taught Patient #2 regarding the two new medications. There was no documentation indicating the patient verbalized understanding of what the medication was for, when to take each medication and side effects to be aware of for each medication.

Patient #3

Patient #3 was admitted on 8/24/09 with diagnoses including pressure ulcer, malignant neoplasm of the lung and low back pain.

According to a 9/12/09 skilled nurse visit note (SNVN) in Patient #3's clinical record, the patient was prescribed a new medication (Anucort). The SNVN lacked documented evidence the SN taught the patient and/or caregiver regarding the medication's purpose, frequency, side effects, etc. There was no documented evidence the patient and/or caregiver verbalized understanding regarding the new medication.

Patient #3's clinical record included a SNVN dated 10/26/09 in which the SN documented the patient was on a new medication (Z-Pak). There was no documentation indicating the SN instructed the patient and/or the caregiver regarding the medication's purpose, frequency, side effects, etc. There was no documented

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G 177	Continued From page 41 evidence the patient and/or caregiver verbalized understanding regarding the new medication.	G 177		
G 186	484.32 THERAPY SERVICES The qualified therapist assists the physician in evaluating the patient's level of function, and helps develop the plan of care (revising it as necessary.) This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review, the agency failed to ensure the physical therapist developed an accurate plan of care for 2 of 24 patients (Patients #2, #22). Findings include: Patient #2 Patient #2 was admitted on 11/14/09 with diagnoses including pressure ulcer, non-insulin dependent diabetes, malignant essential hypertension and debility. Patient #2 was admitted on a Saturday. The agency's week ends on Sunday. The physical therapist (PT) evaluated the patient on Monday, 11/16/09. The PT wrote an order for Patient #2 to be treated three times a week for four weeks. The PT did not specify the frequency was to be effective the week of 11/16/09. Patient #22	G 186		

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G 186	Continued From page 42 Patient #22 was admitted on 5/21/09 with diagnoses including non insulin dependent diabetes mellitus, osteoarthrosis, chronic pain and debility. Physical therapy (PT) evaluated Patient #22 on 5/26/09. PT wrote a physician's order for a frequency of three times a week for two weeks and then, two times a week for three weeks. The physician's order did not specify the PT frequencies were effective as of 5/26/09.	G 186		
G 236	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review, the agency failed to ensure complete clinical records were kept for 2 of 24 patients (Patients #6, #16). Findings include: Patient #6 Patient #6 was admitted on 9/30/08 with diagnoses including venous peripheral	G 236		

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G 236	Continued From page 43 insufficiency, malignant essential hypertension and morbid obesity. As of 12/11/09, there was no medical history (from the referral source or primary physician) in Patient #6's clinical record. Patient #16 Patient #16 was admitted on 11/4/09 with diagnoses including non insulin dependent diabetes mellitus, chronic pain and open wound. As of 12/11/09, there was no medical history (from the referral source or primary physician) in Patient #16's clinical record.	G 236		
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review, the agency failed to ensure ongoing comprehensive assessments of medications occurred for 9 of 24 patients (Patients #1, #3, #5, #6, #7, #8, #9, #12, #13). Findings include: Patient #1 Patient #1 was admitted on 8/1/09 with diagnoses	G 337		

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G 337	Continued From page 44 including non-healing surgical wound, abnormality of gait, essential hypertension and chronic pain. According to a 30 day summary dated 9/1/09, Patient #1 was on Bactrim ... for eight days." The Medication Profile was not updated to reflect the patient was on Bactrim, the date started, dosage, frequency, etc. Patient #3 Patient #3 was admitted on 8/24/09 with diagnoses including decubitus ulcer malignant neoplasm of the lung and low back pain. Patient #3's clinical record included a skilled nurse visit note (SNVN) dated 9/12/09 which indicated the patient was prescribed Anucort 25 milligrams to be taken rectally twice a day. Patient #3's Medication Profile was not updated to reflect the newly added medication. Patient #5 Patient #5 was admitted on 11/29/09 with diagnoses including pulmonary embolism, abnormality of gait, aftercare surgery of musculoskeletal system, degenerative joint disease. On 12/3/09 in the morning during a home visit, Patient #5 indicated she had been taking Benadryl (as needed for itch (prn)) since 11/30, Oxycodone (prn pain) since 12/2 and Albuterol for years (prn shortness of breath) secondary to a lifelong diagnosis of asthma. As of 12/3/09, Patient #5's Medication Profile was	G 337		

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G 337	Continued From page 45	G 337		

not updated to reflect the three medications mentioned in the previous paragraph.

Patient #6

Patient #6 was admitted on 9/30/08 with diagnoses including venous peripheral insufficiency, malignant essential hypertension and morbid obesity.

On 12/11/09 in the morning during a home visit, Patient #6 indicated she had been taking:

-- Lisinopril 10 milligrams every day since 8/18/09;
-- Oxybutynin 5 milligrams two tabs twice a day (label read three times a day, Medication Profile (MP) read once a day);
-- Vicodin at bedtime only (MP read three times a day).

Patient #6's MP was not updated to reflect the changes in the three medications mentioned in the previous paragraph.

Patient #7

Patient #7 was admitted on 11/20/09 with diagnoses including debility, essential hypertension, non-insulin dependent diabetes mellitus, bronchitis and chronic airway obstruction.

Patient #7's Plan of Care (POC) for the certification period of 11/20/09 - 1/18/10 included orders for the following medications:

-- Januvia 25 milligrams (mg) one tablet by mouth once a day

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	297096	A. BUILDING _____ B. WING _____	12/11/2009

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G 337	Continued From page 46 -- Hyzaar 100 mg one tablet by mouth once a day -- Singulair 10 mg one tablet by mouth every 12 hours -- Fioricet 200 mg one tablet by mouth four times a day prn (as needed for) pain On 12/4/09 in the morning during a home visit with the physical therapist, Patient #7 presented medications with the following prescription labels, supplements and over-the-counter pharmaceuticals: -- Januvia 25 mg one tablet by mouth two times a day -- Alprazolam 0.5 mg one tablet by mouth two times a day (dated 9/6/09) -- Hyzaar 100/12.5 mg one tablet by mouth once a day -- Singulair 10 mg one by mouth once a day -- Klor-Con 10 milliequivalents one table by mouth once a day -- Toprol 50 mg one tablet by mouth once a day -- Patanol 0.1% eye drops one drop each eye twice a day -- Lumigan eye drops one drop each eye once daily in the evening -- I-Caps two capsules once a day with meals -- Fish Oil capsule one capsule by mouth once a day -- Stool softener one capsule by mouth once a day Patient #7's clinical record included a skilled nurse visit note dated 11/23/09 in which the nurse documented, "... Azithromycin 250 mg by mouth per dose pack times five days." Patient #7's Medication Profile (MP) lacked	G 337		

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G 337	Continued From page 47 documented evidence of updates reflecting the above mentioned medications (from Januvia to Azithromycin). Patient #8 Patient #8 was admitted on 10/28/08 with diagnoses including insulin dependent diabetes mellitus, diabetic ulcer of the lower leg and chronic airway obstruction. On 12/4/09 in the morning during a home visit, Patient #8's medications included a prescription bottle with a label which read, "Diovan Hct 320/25 milligrams (mg) one tablet by mouth once a day." Patient #8 had a bottle of Risperdal with a label reading, "Risperdal one mg one tablet every day at 4:00 PM." The medication had a dispense date of 10/14/09. Patient #8's most current Medication Profile (MP) which had updates of 10/22/09 and 11/19/09 did not include Risperdal one mg one tablet every day at 4:00 PM. Patient #9 Patient #9 was admitted on 2/25/09 with diagnoses including pressure ulcer of the buttock, essential hypertension, obesity and low back pain. Patient #9's clinical record included a skilled nurse visit note (SNVN) dated 11/16/09 which indicated the patient was taking Docusate 200 milligrams by mouth every day. Patient #9's Medication Profile for the certification	G 337		

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G 337	Continued From page 48 period of 10/23/09 - 12/21/09 lacked documented evidence of being updated to reflect the addition of Docusate. Patient #12 Patient #12 was admitted on 11/15/09 with diagnoses including essential hypertension, abnormality of gait and acute pain. On 12/8/09 in the morning during a home visit, Patient #12 had a bottle of medication with a prescription label which read, "Bupropion Hydrochloride 75 milligrams (mg) one tablet by mouth twice a day." Patient #12 had a bottle of over the counter Aleve 220 mg and indicated she took one tablet by mouth twice a day as needed for pain. The patient indicated the Tylenol #3 was discontinued and was taking the Aleve instead. Patient #12 indicated she was no longer taking Calcium with Vitamin D and Vitamin C (as of 11/30), Megestrol (as of 12/7) and Benadryl (date of discontinuation unknown). Patient #12's medication profile lacked documented evidence reflecting the changes in the patient's medications. Patient #13 Patient #13 was admitted on 12/5/09 with diagnoses including osteomyelitis, insulin dependent diabetes mellitus, essential hypertension, atrial fibrillation and coronary atherosclerosis.	G 337		

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G 337	Continued From page 49 A 7/23/09 postoperative discharge instruction form revealed Patient #13 was prescribed two new medications (Lortab and Keflex). The 7/13/09 medication profile was not updated to reflect these two new medications.	G 337		
G 339	484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review, the agency failed to ensure a recertification assessment was completed during the last five days of the previous certification period for 1 of 24 patients (Patient #9). Findings include: Patient #9 Patient #9 was admitted on 2/25/09 with diagnoses including pressure ulcer of the buttock, essential hypertension, obesity and low back pain. A Recertification Assessment dated 10/17/09	G 339		

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G 339	Continued From page 50 revealed the nurse performed the recertification assessment six days prior to the first day of the new certification period.	G 339		